BEFORE THE WEST VIRGINIA BOARD OF MEDICINE

WEST VIRGINIA BOARD OF MEDICINE,
PETITIONER,

V.

STEVEN B. HEFTER, M.D.,
RESPONDENT.

ORDER

This proceeding arises under the West Virginia Medical Practice Act, West Virginia Code §30-3-1, et seq., and is a disciplinary proceeding involving the status of the license to practice medicine and surgery in the State of West Virginia of Steven B. Hefter, M.D. (hereinafter "Dr. Hefter"). The West Virginia Board of Medicine (hereinafter "the Board") is the duly authorized State agency to oversee and conduct physician disciplinary hearings pursuant to the provisions of West Virginia Code §30-3-14.

PROCEDURAL HISTORY

This matter came on for hearing upon a "Complaint and Notice of Hearing" issued by the Board on April 14, 2004, and the assignment of Anne B. Charnock as Hearing Examiner upon Respondent's failure to designate a Hearing Examiner, dated May 10, 2004. Respondent filed no Answer to the Complaint and Petitioner filed a Motion to Have Allegations Taken as Confessed. The hearing was

convened on July 21, 2004, by Hearing Examiner Anne B. Charnock, in the Conference Room at the Board offices at 101 Dee Drive, Charleston, West Virginia. Dr. Hefter was present in person, and appeared without counsel. The Board was represented at the hearing by its Executive Director, Ronald D. Walton, and by its Prosecutor, Stephen D. Greer, II. Leslie Higginbotham, Investigator and Paralegal for the Board was also present. The Board introduced twenty (20) exhibits, all of which were admitted in the record, and called as its witnesses, Ronald D. Walton, Paul Farrell, and Dr. Hefter. Dr. Hefter introduced one (1) exhibit. Dr. Hefter testified in his own behalf. A stenographic record of the hearing was prepared pursuant to 11 CSR 3 12. Petitioner filed proposed findings of facts and conclusions of law on October 21, 2004. Dr. Hefter filed a two (2) page letter dated October 16, 2004.

In accordance with 11 CSR 3 13.1, the hearing file, the stenographic record of the hearing and the Board's and Respondent's filings described above were provided to Board members for their individual consideration, along with Hearing Examiner Charnock's "Findings of Fact, Conclusions of Law and Recommended Decision of the Hearing Officer" (hereinafter referred to as "Recommended Decision") dated October 27, 2004. At the November 8, 2004, regular meeting of the Board, at which a quorum of the Board was present and voting, the Board thoroughly considered all of this information. Dr. Arnold, Dr. Georges, Dr. Hasan, Dr. Lynch, Dr. Maheswaran, Dr. Wade, Dr. Wazir, Mr. Wright and Ms. Griffin participated in the review, Dr. Hasan opposed the decision, and in accordance with 11 CSR 3 7, the Board reached its decision. Dr.'s Rexrode, Simmons and Smith and Rev. Bowyer did not participate or vote in this matter by virtue of their positions as a member of the Complaint Committee during the

period when the subject matters were before the Complaint Committee. Dr. Slemp was absent. Dr. Georges presided.

Pursuant to 11 CSR 3 14.3, which specifies that the Board may adopt, modify or reject the recommendations of the Hearing Examiner, the Board hereby adopts the section of the Hearing Examiner's Recommended Decision on pages one (1) and two (2) of her Recommended Decision, entitled "Procedural History" and "Motions", to the extent consistent with the Procedural History contained herein. A true and accurate copy of the Recommended Decision is attached hereto.

ISSUES

Pursuant to 11 CSR 3 14.3, which specifies that the Board may adopt, modify or reject the Recommendations of the Hearing Examiner, the Board adopts the section of the Hearing Examiner's Recommended Decision entitled "Issues" on pages two (2) and three (3) of the Recommended Decision.

FINDINGS OF FACT

Pursuant to 11 CSR 3 14.3, which specifies that the Board may adopt, modify or reject the Recommendations of the Hearing Examiner, the Board adopts the Findings of Fact section of the Hearing Examiner's Recommended Decision on pages three (3) through eleven (11).

The Board adds a Finding of Fact #44: "Steven B. Hefter, M.D., is unqualified to practice medicine in the State of West Virginia." West Virginia Code §30-

3-14(j) specifies that sanctions may be imposed against a physician whenever the Board "finds any person unqualified...", and the Board so finds.

DISCUSSION

Pursuant to 11 CSR 3 14.3, which specifies that the Board may adopt, modify or reject the recommendations of the Hearing Examiner, the Board adopts the "Discussion" section of the Hearing Examiner's Recommended Decision on pages eleven (11) and twelve (12), with the following addition:

"To the extent that the findings and conclusions found in this Recommended Decision are generally consistent with any proposed findings of fact and conclusions of law submitted by the parties, the same are adopted by the West Virginia Board of Medicine, and conversely to the extent that the same are inconsistent with these findings and conclusions, the same are rejected."

CONCLUSIONS OF LAW

Pursuant to 11 CSR 3 14.3, which specifies that the Board may adopt, modify or reject the recommendations of the Hearing Examiner, the Board hereby adopts the section of the Hearing Examiner's Recommended Decision entitled "Conclusions of Law", with the following modifications:

On page seventeen (17), after the first sentence of conclusion of law #18, add the words "Petitioner has clearly and convincingly shown that" at the beginning of the second sentence of the paragraph. On page eighteen (18) at the beginning of conclusion of law # 19, add the words "Petitioner has clearly and convincingly shown".

In conclusion of law #20, in the second sentence after "Dr. Hefter" add the words "clearly and convincingly".

DECISION

Pursuant to 11 CSR 3 14.3, which specifies that the Board may adopt, modify or reject the recommendation of the Hearing Examiner, the Board hereby adopts the section of the Hearing Examiner's Recommended Decision entitled "Recommended Decision" and hereby **REVOKES** Dr. Hefter's medical license in West Virginia, effective November 15, 2004. Further, the Board orders that Dr. Hefter be assessed the costs of these proceedings including, but not limited to, attorney fees, hearing officer fees, photocopies and other clerical expenses and Board staff costs. Dr. Hefter shall pay such costs within thirty (30) days of receiving an invoice from the Board for the same.

Entered this 8th day of November, 2004.

Angelo N. Georges, M.D.
President

Catherine Slemp, M.D., M.P.H.
Secretary

CERTIFICATE OF SERVICE

I, Deborah Lewis Rodecker, Counsel for the West Virginia Board of Medicine, do hereby certify that the foregoing **ORDER** was deposited in the United States mail, postage prepaid, and certified, this 8th day of November, 2004, addressed as follows:

Steven B. Hefter, M.D.
PO Box 130622
Birmingham, AL 35213

Deborah Lewis Rodecker

Deborah Lewis Rodecker
West Virginia Bar #3144
West Virginia Board of Medicine
101 Dee Drive
Charleston, West Virginia 25311
(304) 558-2921

BEFORE THE WEST VIRGINIA BOARD OF MEDICINE

WEST VIRGINIA BOARD OF MEDICINE,

PETITIONER,

v.

STEVEN B. HEFTER, M.D.,

RESPONDENT.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND RECOMMENDED DECISION OF THE HEARING OFFICER

On the 21st day of July 2004, came the Petitioner, West Virginia Board of Medicine (Board) through its Executive Director, Ronald D. Walton, and by its counsel, Stephen D. Greer, II, and the Respondent, Steven B. Hefter, M.D., in person, pro se, for a hearing before Anne B. Charnock, Hearing Officer, at the Board's Conference Room at 101 Dee Drive, Charleston, West Virginia upon the complaint filed by the Board.

PROCEDURAL HISTORY

This matter matured for hearing upon: the Petitioner's "Complaint and Notice of Hearing" served on or about April 14, 2004. The Respondent failed to file an "Answer" in this matter and the Petitioner filed a Motion to take the charges as confessed. The Hearing Officer deferred a ruling until the hearing at which time the motion was denied. The parties were instructed by the Hearing Officer to file simultaneous "Proposed Findings of Fact and Conclusions of Law" on/before October 14, 2004. At the Hearing, the Petitioner presented as its witnesses Ronald D. Walton, and

Paul Farrell, Esq., and introduced twenty (20) exhibits which were made a part of the record. Respondent testified on his own behalf, and introduced one (1) exhibit which was made a part of the record.

Petitioner submitted "Proposed Findings of Fact and Conclusions of Law" which the Hearing Officer reviewed. Respondent made no submission.

MOTIONS

All decisions rendered at the aforesaid hearing on motions filed in this action are hereby affirmed and all other motions filed in this action by either of the parties which were not previously ruled upon by the hearing officer are hereby denied and rejected.

ISSUES

1. Whether Respondent violated the hospital By-Laws of Raleigh General Hospital by repeatedly performing "elective peripheral angiography" without having the privileges at the hospital to do so, in violation of West Virginia Code §30-3-14(c)(9) and (17) and 11 CSR 1A 12.1(s)?

2. Whether Respondent violated the hospital By-Laws of Raleigh General Hospital by repeatedly performing "elective peripheral angiography" without having the privileges at the hospital to do so, in violation of West Virginia Code §30-3-14(c)(17) and 11 CSR 1A 12.1(e) and (j)?

3. Whether Respondent's failure to document the numerous "elective peripheral angiography" procedures in the patients' medical records constitutes a violation of West Virginia Code §30-3-14(c)(11) and (17) and 11 CSR 1A 12.1(u)?

4. Whether Respondent's failure to obtain the fully informed consent from those patients he performed "elective peripheral angiography" on constitutes a violation of West Virginia Code §30-3-14(c)(17) and 11 CSR 1A 12.1(x)?

FINDINGS OF FACT

1. Respondent, Steven Bruce Hefter, M.D. ("Dr. Hefter") holds a license to practice medicine and surgery in West Virginia, License No. 15620, issued originally in September 1998. Currently, Dr. Hefter's licensure status is inactive. Dr. Hefter's address of record with the Board is in Birmingham, Alabama. Board Exhibit 1. TR at 9.

2. Dr. Hefter does not practice medicine in West Virginia at this time. He is currently working in Hattiesburg, Mississippi as a Cardiologist. Board Exhibit 1.

3. While practicing in West Virginia, Dr. Hefter worked as a cardiologist at Greenbrier Valley Medical Center, Summersville Memorial Hospital, Pocahontas Memorial Hospital, Summers County Hospital and at Raleigh General Hospital in Beckley, West Virginia. Board Exhibit 2.

4. On June 10, 2002, Dr. Hefter completed the "application for renewal of license to practice medicine and surgery in the State of West Virginia" (renewal application). The Petitioner received Dr. Hefter's renewal application on or about July 15, 2002. Board Exhibit No.2

5. The renewal application was for the period beginning July 1, 2002, to June 30, 2004. Board Exhibit 2.

6. However, there are a series of fifteen (15) questions on page five (5) of the renewal application that relate back to the previous two-year period of July 1, 2000 to June 30, 2002. Dr. Hefter answered in the affirmative to question number six (6), which asks the applicant if during the previous two-year period he "had any hospital privileges limited, restricted, suspended, revoked, or subjected to any kind of disciplinary action, including censure, reprimand or probation?" Board Exhibit 2. TR at 11.

7. Petitioner's witness, Ronald D. Walton, the Executive Director of the Board, testified that the instructions following these questions asks the licensee if an answer was "yes" to any of the questions an explanation should be provided. According to Mr. Walton, Dr. Hefter did provide an explanation in the form of a letter and a brief filed by Dr. Hefter's attorney at the disciplinary hearing previously held at Raleigh General Hospital. Board Exhibit 2. TR at 11-12.

8. Dr. Hefter explained that his privileges to perform cardiac catheterizations were suspended at Raleigh General Hospital for "violation of by-laws" and not for "any clinical, technical or medical reason or for any bad or hazardous outcome for any patient." Board Exhibit 2. TR at 12.

9. In the same letter of explanation, Dr. Hefter also stated that he had performed over 250 peripheral angiographies from 1997 to 2000 without complications. Dr. Hefter stated that his problems began at Raleigh General Hospital in 1999 when he wrote of his intention to be trained in peripheral angioplasty, a more extensive procedure. Board Exhibit 2.

10. According to Dr. Hefter's explanation to the Board, it was a result of his request to do more extensive peripheral procedures that caused the radiology

group. who had an exclusive contract with Raleigh General Hospital for imaging procedures, to insist that he stop performing any peripheral procedures with his cardiac catheterization. Dr. Hefter stated in the same letter to the Board that he was warned by the Executive Committee of Raleigh General Hospital to stop performing the peripheral angiographies. Dr. Hefter stated that "this argument persisted for a year and through three hearings and I lost and was suspended." Petitioner's Exhibit 2.

11. Mr. Walton testified that while Dr. Hefter's license was renewed, Mr. Walton informed Dr. Hefter by letter dated July 15, 2002, that the licensure renewal was in no way to be construed as a "waiver" of the Board's right to proceed with an investigation and possible disciplinary action. TR at 12-13.

12. This information was sent to the Licensure Committee who then made a determination to refer the matter to the Complaint Committee on September 7, 2002. TR at 13.

13. The Complaint Committee decided to initiate its own complaint against Dr. Hefter, which complaint was sent to him by certified mail along with a letter from Dr. Lee Elliott Smith, Chair of the Complaint Committee, that Dr. Hefter had thirty (30) days to answer the complaint in writing. Petitioner's Exhibit 3. TR at 14-15.

14. The initiated complaint states that "it appears that Dr. Hefter is or may be in violation of West Virginia Code §30-3-14(c)(11) and 11 CSR 1A 12.1(u), relating to failure to keep written records justifying the course of treatment; West Virginia Code §30-3-14(c)(9) and 11 CSR 1A 12.1(s), relating to making a deceptive, untrue, or fraudulent representation in the practice of medicine and surgery; 11 CSR 1A 12.1(e), relating to dishonorable, unethical, or unprofessional conduct of a character

likely to deceive, defraud, or harm the public; West Virginia Code §30-3-14(c)(5) and 11 CSR 1A 12.1(p), relating to making or filing a report known to be false; West Virginia Code §30-3-14(c)(15) and 11 CSR 1A 12.1(z), relating to performing professional responsibilities the licensee knows or has reason to know he is not competent to perform; 11 CSR 1A 12.1(j) and 11 CSR 1A 12.2(d) and (g), and; West Virginia Code §30-3-14(c)(17) and 11 CSR 1A 12.1(bb), relating to violating the Medical Practice Act or a duly promulgated legislative rule of the Board, for which violations Dr. Hefter may be disciplined by the Board." Petitioner's Exhibit 3.

15. On November 11, 2002, Dr. Hefter sent an "answer" in response to the Complaint Committee's initiated complaint (Complaint No. 02-119-W), in which Dr. Hefter "categorically" denied the charges and allegations set forth. Petitioner's Exhibit 5.

16. Mr. Walton testified that he sent Dr. Hefter a certified letter dated February 7, 2003, to give him ample notice that he was to appear before the Complaint Committee regarding the initiated complaint at the next Complaint Committee meeting either on March 8, 2003, or March 9, 2003. Petitioner's Exhibit 6, TR. at 18 – 19.

17. On February 21, 2003, Mr. Walton sent another certified letter to Dr. Hefter notifying him that he was scheduled to appear before the Complaint Committee on March 9, 2003. Petitioner's Exhibit 7, TR. at 20.

18. Dr. Hefter failed to appear at the March 9, 2003, meeting. TR. at 21.

19. Both the February 7, 2003, and the February 21, 2003, letters were sent to the two (2) addresses that Dr. Hefter had provided to the Board. TR. at 19.

20. On March 17, 2003, Mr. Walton mailed Dr. Hefter another certified letter advising him that he would be subpoenaed to appear at the next Board meeting on May 11, 2003. Dr. Hefter failed to respond to the subpoena which was also sent by certified mail to Dr. Hefter's Lewisburg, West Virginia address and to his Birmingham, Alabama address on April 18, 2003. The signature card was signed by "Marcie Hefter" at the Lewisburg address. Petitioner's Exhibit 8, TR. at 21 – 22.

21. Dr. Hefter was sent a subpoena by certified mail on April 18, 2003. This subpoena was sent to the same Lewisburg, West Virginia address where the previous letter was signed for, and it was also mailed to the Birmingham, Alabama address that Dr. Hefter listed with the Board. However, no one signed for the subpoena at either address. Petitioner's Exhibit 9, Tr. at 22 – 23.

22. Mr. Walton testified that one of a physician's duties is to advise the Board as to any change of address. He testified that he knew of no such change of address requested by Dr. Hefter. TR. at 23 – 24.

23. Dr. Hefter wrote a letter to the Board dated May 8, 2003, in which he informed the Board that he could not attend the May 11, 2003, Complaint Committee meeting due to personal and financial reasons. Petitioner's Exhibit 10, Tr. at 24.

24. Dr. Hefter also informed the Board in the May 8, 2003, letter that "I have no intention of practicing medicine ever again in West Virginia ..." Petitioner's Exhibit 10. TR at 25.

25. In response, the Complaint Committee requested by certified letter dated June 6, 2003, that Dr. Hefter attend the July 12, 2003, meeting. The Complaint Committee also sent a proposed "Consent Order" with the letter offering Dr. Hefter the

option of voluntarily surrendering his license in lieu of appearing at the July 12, 2003, meeting. Petitioner's Exhibit 11, TR. at 25 – 26.

26. As a result of Dr. Hefter's request to appear, the Complaint Committee sent another letter to Dr. Hefter dated October 15, 2003, and attached another subpoena requesting that he appear at the November 9, 2003, meeting. However, again Dr. Hefter did not appear. Petitioner's Exhibit 13, TR. at 28 – 29.

27. Given Dr. Hefter's refusal to appear at any of the above mentioned Complaint Committee meetings, the Complaint Committee filed a "Complaint and Notice of Hearing" against Dr. Hefter on or about April 14, 2004. Petitioner's Exhibit 14.

28. Paul Farrell, General Counsel for Raleigh General Hospital, testified for the Petitioner that he advises the administrative officers at the hospital including the "Executive Credentials Committee". TR. at 35 – 36.

29. Mr. Farrell has served as Counsel for Raleigh General Hospital at several hearings within the By-Laws of the hospital dealing with medical staff suspensions, restrictions and privileges, including the present matter involving Dr. Hefter. TR. at 36.

30. Mr. Farrell testified that medical staff privileges are issued to physicians based upon the physicians' application to perform certain procedures at the hospital, and that the By-Laws of Raleigh General Hospital provide that a physician may only practice within those areas in which he is granted specific privileges. Petitioner's Exhibit 15, TR. at 37.

31. According to Mr. Farrell, Dr. Hefter applied for privileges to perform peripheral angiography procedures and stinting beginning in 1999, but was denied such privileges. Petitioner's Exhibit 15. TR. at 38.

32. Mr. Farrell testified that there developed a concern at Raleigh General Hospital that Dr. Hefter was exceeding the privileges granted to him and was in fact performing peripheral angiography and stenting procedures. There was a series of letters from the "Executive Credentials Committee" warning Dr. Hefter that he was exceeding his privileges granted to him by the medical staff. Petitioner's Exhibit 15, Tabs. E, H, L, N, O. TR. at 38.

33. Dr. Hefter was directed to cease performing these procedures at least six (6) times by the "Executive Credentials Committee" and on April 12, 2000, he received a certified letter from Raleigh General Hospital stating that "this is your last warning with regard to peripheral angiography." Further, the letter informed him that any further such incident would result in Dr. Hefter's immediate suspension of all privileges for thirty (30) days and that such suspension would be reportable to the National Practitioner's Data Bank. Petitioner's Exhibit 15, Tab N.

34. On July 19, 2000, the Medical Staff President of Raleigh General Hospital sent a certified letter to Dr. Hefter advising him that the "Executive Credentials Committee" reviewed his dictation regarding two (2) unidentifiable patients and determined that "it is obvious from your dictation that you performed peripheral scans that you have been directed not to perform." As a result of this discovery, and the fact that he had been warned numerous times to stop performing these studies, Dr. Hefter's staff privileges were suspended for twenty-one (21) days. Petitioner's Exhibit 15, Tab S.

35. Despite the warnings and the temporary suspension, Dr. Hefter continued to perform peripheral angiographies during cardiac catheterziations that he was not privileged to do. As a result, the "Executive Credentials Committee" recommended that Dr. Hefter's privileges be revoked at its June 13, 2001, meeting. Petitioner's Exhibit 15, Tab Z.

36. Mr. Farrell testified that the "Executive Credentials Committee" provided Dr. Hefter with a formal notice of the complaint made against him pursuant to the By-Laws of Raleigh General Hospital. Petitioner's Exhibit 16, TR. at 40.

37. Mr. Farrell testified that the By-Laws provided a due process system and that Dr. Hefter was given formal notice, the right to counsel, and the right to an appeal. TR. at 40 – 41.

38. According to Mr. Farrell, a five (5) member panel was appointed by the "Executive Credentials Committee" to act as the hearing panel in the disciplinary hearing held at Raleigh General Hospital. In addition, pursuant to the By-Laws, Vince King, Esquire, served as the hearing examiner and assisted in directing the proceedings. Petitioner's Exhibit 18, TR. at 41.

39. Dr. Hefter hired counsel to represent him at the disciplinary hearing, which was held on September 20, 2001. Petitioner's Exhibits 15 and 18, TR. at 41.

40. Mr. Farrell testified that a full presentation of the evidence was made at the disciplinary hearing at Raleigh General Hospital. Dr. Hefter testified and his counsel presented witnesses and evidence on his behalf. In addition, his counsel was able

to cross-examine Raleigh General Hospital's witnesses. Petitioner's Exhibit 18, TR. at 41.

41. The Hearing Panel at Raleigh General Hospital made a recommendation that Dr. Hefter be suspended for one (1) year beginning June 14, 2001. Thus, the Hearing Panel reduced Dr. Hefter's punishment from permanent revocation to one (1) year suspension. Petitioner's Exhibit 19, TR. at 41.

42. Dr. Hefter appealed this decision to the Board of Trustees at Raleigh General Hospital, who acts in a manner similar to an appellate Court. Based upon the transcript and argument of counsel, the Board of Trustees affirmed but modified the Hearing Panel's recommendation so that Dr. Hefter's suspension ran from January 1, 2002, through January 1, 2003. Petitioner's Exhibit 20, TR. at 42.

43. Dr. Hefter contends that the argument over this procedure is really an argument not over quality of care issues but rather a dispute with the radiologists. TR. at 58-66.

DISCUSSION

CREDIBILITY OF WITNESSES, TESTIMONY AND EXHIBITS

The Hearing Officer was satisfied that all witnesses testified truthfully. Neither the demeanor of any witness nor the substance of any testimony suggested any inconsistency, conflict or ulterior motive. No evidence suggested any personal gain to be achieved by any witness as a result of testifying.

The following exhibits were introduced into evidence:

1. Petitioner's Exhibit 1-Public Report of Licensee with History
2. Petitioner's Exhibit 2-License Application-July 1, 2002-June 30, 2004

3. Petitioner's Exhibit 3-November 1, 2002 Letter to Dr. Hefter
4. Petitioner's Exhibit 4-Change of Address Form
5. Petitioner's Exhibit 5-November 11, 2002 Letter from Dr. Hefter
6. Petitioner's Exhibit 6-February 7, 2003 Letter to Dr. Hefter
7. Petitioner's Exhibit 7-February 21, 2003 Letter to Dr. Hefter
8. Petitioner's Exhibit 8-March 14, 2003 Letter to Dr. Hefter
9. Petitioner's Exhibit 9-Subpoena for May 11, 2003 hearing
10. Petitioner's Exhibit 10-May 8, 2003 Letter from Dr. Hefter
11. Petitioner's Exhibit 11-June 6, 2003 Letter to Dr. Hefter
12. Petitioner's Exhibit 12-July 2, 2003 Letter from Dr. Hefter
13. Petitioner's Exhibit 13-October 15, 2003 Lette to Dr. Hefter
14. Petitioner's Exhibit 14-Subpoena for July 21, 2004 hearing
15. Petitioner's Exhibit 15-Index with Attached Documnets
16. Petitioner's Exhibit 16-Raleigh General Hospita Bylaws –March, 2001
17. Petitioner's Exhibit 17-Raleigh General Hospital Rules and Regulations of the Medical Staff-March 2001
18. Petitioner's Exhibit 18-Disciplinary Hearing Transcript-September 20, 2001
19. Petitioner's Exhibit 19-Memorandum-September 24, 2001
20. Petitioner's Exhibit 20-Raleigh General Hospital Report of the Board of Trustees
21. Respondent's Exhibit 1-July 24, 200 Letter to Dr. Daniel

CONCLUSIONS OF LAW

1. The Respondent is a physician licensed in the State of West Virginia and the West Virginia Board of Medicine is the state agency charged with licensure and discipline of physicians under West Virginia Code §30-3-1 et seq.

2. The West Virginia Board of Medicine has jurisdiction over the subject matter and over the Respondent.

3. The Petitioner bears the burden of proving the allegations in its complaint by clear and convincing evidence. *Webb v. W.Va. Board of Medicine*, 569 S.E.2d 225, 231 (W.Va. 2002).

4. The practice of medicine is a privilege. West Virginia Code §30-1-1a and §30-1-1.

5. The State may attach conditions "onerous and exacting" to this privilege. *Barksy v. Board of Regents*, 11 N.E.2d 22 (N.Y.1953). reh.den 112 N.E.2d 773, Affirmed 347 U.S. 442, 74 S.Ct. 650. Cited in West Virginia Board of Medicine v. William Lee Mossburg, M.D., 2003, and in West Virginia Board of Medicine v. Maria DeJesus Baltierra, M.D. (2002).

6. Physicians must "possess a surpassing degree of ethical commitment..." *North v. West Virginia Board of Regents*, 332 S.E.2d 141 (W.Va. 1985). Deceptive conduct such as that found here flies in the face of such a requirement.

7. It is also appropriate to take into consideration in this matter Board of Medicine precedent under the provisions of West Virginia Code §29A-2-9.

8. Whether or not expert testimony is offered at hearing, an independent review of the evidence of record by a board with the requisite qualifications in the profession under its scrutiny is proper, and boards comprised of members of the profession they oversee may base their decision on the collective expertise of those members by filtering expert documentary evidence presented before the hearing examiner through the lens of its own expertise. See *Batoff v. State Board of Psychology*, 750 A.2d 835 (PA. 2000)

9. Determinations concerning Respondent's conduct relative to the standards set forth at 11 CSR 1A 12.1(e) and (j) relating to unprofessional conduct may properly be made by the Board without expert testimony. (See *Mingo County Medical Society v. Simon* 20 S.E.2d 807 (W.Va. 1942); *In Re Hawkins*, 194 S.E.2d 540 (N.C.1973) *Cert den.* 196 S.E.2d 275 (1973). *Cert. den.* 414 U.S. 1001, 94 S.Ct. 355 (1973). *Watkins v. State Board of Dental Examiners*, 593 S.E.2d 764 (N.C. 2004)

10. The inherent object of statutes such as the Medical Practice Act in regulating the practice of medicine, surgery and podiatry is the preservation of the public health. *Vest v. Cobb*, 138 W.Va. 660, 76 S.E. 2d 885 (1953).

11. West Virginia Code §30-3-14(a) gives the Board the power to initiate disciplining proceedings based on information received from medical peer review committees, physicians, podiatrists, hospital administrators, professional societies and others.

12. West Virginia Code §30-3-14(b) states in part that "the chief executive officer of every hospital shall within sixty (60) days after the completion of the hospital's formal disciplinary procedure ...." Report in writing to the Board the name of

any member of the medical staff or any other physician ... practicing in the hospital whose hospital privileges have been revoked, restricted, reduced or terminated for any cause, including resignation, together with all pertinent information relating to such action.

13. The West Virginia Board of Medicine may utilize the assessment of the West Virginia Peer Review Organization in its determination whether to revoke a license to practice medicine if the assessment is sufficiently detailed to determine the alleged improper or unnecessary care and satisfies the notice requirements of West Virginia Code § 29A-5-1. *Pritchard v. Catterson*, 184 W.Va. 542, 401 S.E.2d 475. (1990).

14. In *Pritchard v. Catterson*, the West Virginia Medical Institute, Inc., served as the Peer Review Organization ("PRO") in West Virginia for the Department of Health and Human Resources for the Federal Government. 184 W.Va. 542, 544. The PRO reviewed cases which the respondent had submitted to Medicare for payment and determined that he should be excluded from the Medicare program for violating certain obligations of the Social Security Act and for providing care that was medically unnecessary or failed to meet the professionally recognized standard of care. Id at 545. The Court found that the Board did not abrogate its duty by relying on the finding of facts as established by the PRO. Id at 547. The Court concluded that the Board of Medicine may utilize the assessment of the Peer Review Organization where the respondent's due process rights are not harmed by the proceedings and that the respondent receives a full and fair hearing before an independently appointed hearing examiner. Id. The Court concluded that it would be unreasonable and a waste of

resources and time to require the Board of Medicine to reexamine, individually, every case discussed in detail by the Peer Review Organization, which is an agency made up of physicians whose sole duty it is to review such cases. Id.

15. The facts in the present case against Dr. Hefter are very similar with the only exception being that the hearing was held before a panel of five physicians, who like Dr. Hefter, had privileges at Raleigh General Hospital. Petitioner's Exhibit 18, (pp.4-5). Dr. Hefter had counsel who presented witnesses, evidence, and cross-examined Raleigh General Hospital's witnesses. Petitioner's Exhibit 18. In addition, there was an independently appointed hearing examiner and the By-Laws of Raleigh General Hospital were fairly applied throughout the process.

16. Thus, based upon the *Catterson* case and judicial efficiency, the Board of Medicine reasonably relies on the findings of the five-member hearing panel of physicians at Raleigh General Hospital and the Board of Trustees who served as the appellate body. The five physicians on the hearing panel were in the best position to determine the facts before them and to reach a conclusion on the issues. *See Pritchard v. Catterson*, 184 W.Va. 542, 401 S.E.2d 475. (1990). Petitioner's Exhibit 19.

17. The Hearing Panel composed of Dr. Hefter's peers at Raleigh General Hospital voted unanimously that Dr. Hefter "knowingly practiced outside of his delineation of privileges" by performing numerous peripheral angiography scans including imaging of the coronary artery system. Petitioner's Exhibit 19. The hearing panel concluded such and the Board adopts the same conclusion based upon the following facts and evidence adduced at the hearing at Raleigh General Hospital:

a. Dr. Hefter failed to prove that imaging of the carotid arteries is in fact covered under coronary artery angiography. The hearing panel heard testimony from two (2) expert witnesses and letters provided by three (3) additional experts that while aortic scanning may be considered part of coronary artery angiography, such imaging of the carotid artery system is not part of the procedure of coronary artery angiography. Dr. Hefter did have privileges to perform coronary artery angiography, but he did not have privileges to perform peripheral angiography procedures such as carotid artery imaging. It is undisputed that Dr. Hefter performed carotid artery imaging on numerous patients. Petitioner's Exhibit 19.

b. Further, Dr. Hefter requested coronary angiography and peripheral angiography as separate items or privileges and in all cases his request for peripheral angiography was declined. The hearing panel concluded that the fact he made these requests separately indicated that he recognized peripheral angiography was a separate privilege. Petitioner's Exhibit 19.

18. To knowingly practice outside of his delineation of privileges not only violated the By-Laws of Raleigh General Hospital, but also the Medical Practice Act specifically West Virginia Code §30-3-14(c)(9) and 11 CSR 1A 12.1(s). Dr. Hefter made continuous deceptive, untrue and fraudulent representations in the practice of medicine by continuing to perform peripheral angiography procedures when he knew he did not have the privileges to do so. This conduct is deceptive and fraudulent not only to the

Medical Staff at Raleigh General Hospital, but more importantly to the patients whom he performed the procedures on.

19. In addition, Dr. Hefter's conduct in knowingly practicing outside of his privileges violates Rule 11 CSR 1A 12.1(e) and (j). Dr. Hefter misrepresented to Raleigh General Hospital and the patients he treated that he was performing only those medical procedures that he had been given the authorization or privilege to do. Dr. Hefter testified at the hearing at Raleigh General Hospital that he had been at the meeting where the radiology department and the invasive cardiologists including Dr. Hefter agreed to follow certain guidelines. Petitioner's Exhibit 15 (Tab I). However, Dr. Hefter admitted that he did not follow the guidelines that he just agreed upon, which ultimately caused him to lose his privileges. Petitioner's Exhibit 15 (Tab I) and Petitioner's Exhibit 18 (p.152). Instead, Dr. Hefter testified before the hearing panel that he felt the restrictions were "wrong so I continued to do what was right for the patient." Petitioner's Exhibit 18 (p.139). Dr. Hefter's conduct was clearly in violation of Rule 11 CSR 1A 12.1(e), which prohibits dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

20. The Board also established by clear and convincing evidence that Dr. Hefter's conduct violated Rule 11 CSR 1A 12.1(j) by performing various medical procedures which he knew he was not authorized or privileged to perform, such conduct was unprofessional. Further, in refusing to stop performing peripheral angiographies after numerous warnings, Dr. Hefter acted contrary to honesty, justice and good morals also in violation of 11 CSR 1A 12.1 (j).

21. The Board has established by clear and convincing evidence that Dr. Hefter has violated West Virginia Code §30-3-14(c)(17) and 11 CSR 1A 12.1 (x) by failing to obtain informed consent which is malpractice and below the level of care, skill, and treatment which is recognized by a reasonable prudent physician engaged in the same or similar condition or circumstance based upon the following reasons. Except in very extreme cases, a surgeon has no legal right to operate upon a patient without his consent. *Browning v. Hoffman*, 90 W.Va. 568, 581, 111 S.E. 492, 497 (1922). A physician has a duty to disclose information to his or her patient in order that the patient may give to the physician an informed consent to a particular medical procedure such as surgery. In the case of surgery, the physician ordinarily should disclose to the patient various considerations including (1) the possibility of the surgery, (2) the risks involved concerning the surgery, (3) alternative methods of treatment, (4) the risks relating to such alternative methods of treatment, and (5) the results likely to occur if the patient remains untreated. *Cross v. Trapp*, 170 W.Va. 459, 294 S.E.2d 446 (1982). In evaluating a physician's disclosure of information to his patient, relative to whether that patient gave an informed consent to a particular medical procedure, the Court has adopted the "patient needs standard." *Cross v. Trapp* at *Syllabus Point 3*. Pursuant to this standard, the need of the patient for information material to his decision as to the method of treatment is the standard by which the physician's duty to disclose is measured. *Id.* Therefore, whether a particular medical risk should be disclosed by the physician to the patient depends upon the existence and materiality of such risk with respect to the patient's decision relating to medical treatment. *Id.*

Further, the Medical Staff Rules and Regulations of Raleigh General Hospital also provide a duty to disclose sufficient information to the patient so that the patient can give an informed consent. Raleigh General Medical Staff Rules and Regulations (Item 14) states in part that:

"Informed consent must be obtained by the physician prior to the performance of procedures for which it is required by the policy of the applicable medical staff department to include:

(C) major diagnostic or therapeutic procedures.

The medical record shall contain evidence of the informed consent which documents what was explained to the patient and that the patient understood and agreed to the proposed treatment."

a. The Board has established by clear and convincing evidence that Dr. Hefter failed to obtain informed consent from the majority of the patients on whom he admits to performing peripheral angiography. The hearing panel at Raleigh General Hospital concluded in its decision that "of great concern to members of the panel and despite claims by Dr. Hefter that his actions were in the best interest of the patient, were the admitted lack of obtaining informed consent and documenting observations made during these angiography studies." Members of the panel believed that it would have been in the patient's best interest for informed consent to be obtained and most certainly for any documented aorto-iliac, femoral, or carotid observations to be placed in the permanent patient record. See Petitioner's Exhibit 19.

b. Further, the "Executive Credentials Committee" by letter dated September 20, 1999, asked Dr. Hefter if he had obtained informed consent from any of the one-hundred (100) patients on whom he admitted performing peripheral angiography procedures during the time period which he did not have such privileges. See Petitioner's Exhibit 15, Tab E. Dr. Hefter responded by letter that "consent form errors have occurred" but these errors have been corrected. See Petitioner's Exhibit 15, Tab F.

c. At the disciplinary hearing before his peers on the hearing panel at Raleigh General Hospital, upon being asked if he had obtained specific informed consent from his patients to perform a peripheral carotid artery study; He answered "I have informed consent of my patient when I talk to them. It may not be written down exactly, but it says cardiac catheterization." See Petitioner's Exhibit 18 (p.144)

d. The most damaging evidence against Dr. Hefter in regards to his failure to gain informed consent comes from testimony he gave before his peers on the hearing panel at Raleigh General Hospital; and from staff nurses who assisted Dr. Hefter during many of these procedures. First, three (3) different patients' medical records were introduced at the peer review hearing at Raleigh General Hospital, and all names were redacted to protect patient privacy. See Petitioner's Exhibit 15, Tabs W,X,Y. All three (3) patients' records contained informed consent forms for diagnostic heart catheterization, but there was no specific mention of angiography despite the fact that all three (3) patients had angiography

procedures performed by Dr. Hefter. Dr. Hefter denied ever performing elective peripheral angiography procedures, but admits that he did perform peripheral angiographies while performing a cardiac catheterization. See Petitioner's Exhibit 18 (p.156). However, this testimony was refuted by the two (2) staff nurses who worked in the cardiac catheterization lab. They testified before the hearing panel at Raleigh General Hospital that they had observed Dr. Hefter perform carotid scans in "at least 80 to 85 per cent of his cases". Petitioner's Exhibit 18 (p.98). However, one (1) of the staff nurses testified that the other cardiologists that she assists in the lab do carotid scans approximately one per cent of the time. Petitioner's Exhibit 18. (p.98). Further, Dr. Hefter's own expert witness at the hearing, Dr. McFarlane, admitted on cross-examination, that if prior to a cardiac catheterization he also planned to perform a peripheral carotid scan during the same procedure, he would obtain specific informed consent for the peripheral carotid scan. He testified that he would get a separate consent for the peripheral carotid scan. Petitioner's Exhibit 18 (p.112). Dr. McFarlane also testified that he would document the findings and that it was highly unusual for a physician to do a carotid study in 80% of his cardiac catheterizations. Petitioner's Exhibit 18 (pp.112 and 124).

It is clear that Dr. Hefter failed to obtain informed consent from his patients to conduct peripheral angiography scans especially carotid scans. It is clear from the evidence that, in order to avoid leaving a paper trail or evidence that he was continuing to perform procedures outside of his delineation of privileges, Dr. Hefter did

not inform his patients that he was going to perform a peripheral scan of the carotid artery. It is not sufficient for Dr. Hefter to defend his conduct by stating that he verbally informed some of these patients. Unless the patient's consent is in writing, there is a presumption that informed consent was not obtained.

22. The Board has proven by clear and convincing evidence that Dr. Hefter violated West Virginia Code §30-3-14(c)(11) and (17) and 11 CSR 1A 12.1 (u) in that he failed to keep written records justifying the course of treatment of his patients and he failed to document examination results and test results. The hearing panel at Raleigh General Hospital concluded after hearing all the testimony and reviewing the evidence that " it would have been in the patient's best interest for informed consent to be obtained and most certainly for any documented aorto-iliac, femoral or carotid observation to be placed into the permanent patient record." Petitioner's Exhibit 19. In addition, Dr. Hefter admitted to his peers on the hearing panel at Raleigh General Hospital that he did not always document information in the patient's hospital chart. Dr. Hefter admitted that he did not dictate each time he did a carotid artery study and that such practice was not good medicine. See Petitioner's Exhibit 18, (p.145). He was specifically asked under oath " You're not putting in your charts of these patients that some other physician may have to rely on that you've done a carotid, be it partial or otherwise, on these patients?" He answered, "I usually document it somewhere." See Petitioner's Exhibit 18, (p.146). When asked what this meant, he stated that he would send "a letter to another physician who the patient is being sent to, verbalization to another doctor, telling the patient." See Petitioner's Exhibit 18, (p.146). He testified that he does not always make a written record available to the physicians at Raleigh General Hospital. Petitioners Exhibit 18,

(p.146). Thus, it appears that Dr. Hefter placed himself in a proverbial "catch 22" by doing procedures that he was not privileged to perform, he was hesitant to admit to doing such procedures in the patient's medical records which would be an admission of his violations. However, by failing to document his findings from these procedures, he further jeopardized patient safety and demonstrated further errors in his judgment.

RECOMMENDED DECISION

Based upon the forgoing Findings of Fact and Conclusions of Law, the Hearing Officer respectfully recommends to the Board that the following disciplinary action be taken:

1. That Dr. Hefter's medical license be revoked.

2. That Dr. Hefter be assessed the costs of these proceedings including, but not limited to, attorney fees, hearing officer fees, photocopies and other clerical expenses and Board staff costs.

Dated October 27, 2004

ANNE B. CHARNOCK
Hearing Officer